DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 0 2 — 0 1 5

2. STATE: North Dakota

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
August 1, 2002

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 447 subpart C

7. FEDERAL BUDGET IMPACT:
a. FFY 2002 $ -223,389 savings
b. FFY 2003 $ -1,196,888 savings

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-A, page 1, 2, 2a, 5

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-A, page 1, 2, 2a, 5

10. SUBJECT OF AMENDMENT:
Inpatient services

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
David J. Zentner

14. TITLE:
Director, Medical Services

15. DATE SUBMITTED:
August 7, 2002

16. RETURN TO:
David J. Zentner
Director, Medical Services
ND Department of Human Services
600 E Boulevard Ave-Dept 325
Bismarck ND 58505

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
August 12, 2002

18. DATE APPROVED:
11/8/02

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
August 1, 2002

20. SIGNATURE OF REGIONAL OFFICIAL:
Barn for Smith

21. TYPED NAME:
CHARLENE BROWN

22. TITLE:
Deputy Director, CMSO

23. REMARKS:

FORM HCFA-179 (07-92)

Instructions on Back

METHOD FOR REIMBURSING INPATIENT HOSPITAL SERVICES

1. Hospitals paid using Prospective Payment System (PPS).

   a. In-state hospital service reimbursement paid to all hospitals and distinct part units, except those hospitals and distinct part units specifically identified in Section 2, will be made on the basis of a Prospective Payment System (PPS). The system generally follows the Medicare PPS in terms of the application of the system. PPS uses diagnostic related groups (DRG) to pay for services upon discharge. Medical education costs are excluded from the PPS and are paid on a reasonable cost basis.

   b. The base year used for the calculation of rates is the year ending June 30, 1992.

   c. Hospitals will be grouped into two groups based on the average number of Medicaid discharges for the years ended June 30, 1992, 1993 and 1994.

      (1) Group One - The base rate for a hospital with average discharges in excess of 100 per year will be based on the lower of actual cost or $2,155 but may not be less than $1,506.

      (2) Group Two - The base rate for a hospital with less than an average of 100 discharges per year will be $1,506.

   d. The DRG classification and grouper system is the same as used for Medicare as approved by Centers for Medicare and Medicaid Services. The grouper is updated annually.

   e. The DRG relative weights are calculated from North Dakota Medicaid data as of June 30, 1984 using the Medicare calculation methodology. DRG relative weights are compared annually for significant variances and adjustments may be made.

   f. An update factor may be applied annually to the previous year's base rate. The update factor may not exceed the update factor for PPS hospital operating systems determined annually by the Centers for Medicare and Medicaid Services and published in the federal register.

   g. A capital payment will be included in the PPS payment for all discharges. Capital payments may not be paid to a transferring hospital. The capital payment shall be the lesser of $275 or the capital payment per discharge calculated from the latest cost settlement report on file as of June 30, 2002. The capital payment may be updated annually by the inflation factor applied to the hospital's base rate as determined in paragraph f.

   h. Outlier Payments.

      (1) A cost outlier payment is made when costs exceed a threshold of two times the DRG rate or $15,000, whichever is greater. Costs above the threshold will be paid at 60 percent of billed charges.

(2) A day outlier payment is made when the length of stay for a recipient exceeds the lesser of the geometric mean length of stay plus twenty days or 1.94 standard deviations from the mean for any given DRG. Each day exceeding the threshold is paid at 60 percent of the per diem rate. The per diem rate is calculated as the hospital's basic DRG payment divided by the geometric mean length of stay.

(3) For DRG's 385-390 relating to neonates:

(a) The day outlier payment is calculated at 80% of the per diem rate once the thresholds in paragraph 2 are met; or

(b) The cost outlier thresholds are the greater of 1.5 times the DRG rate or $12,000. Costs above the threshold will be paid at 80 percent of billed charges.

(4) If the thresholds for both a cost outlier and a day outlier are met, only the day outlier payment method will apply.

i. Transfers. Payment will be the full DRG payment, inclusive of outliers, to the final hospital. Per diem payments will be made to the transferring hospitals. Total per diem payments to transferring hospitals may not exceed the full DRG payment, exclusive of outliers. Per diem is the basic DRG payment divided by the geometric mean length of stay. A patient may be transferred to another hospital and then transferred back to the original hospital which becomes the final hospital, in such case, the original hospital will not receive per diem payments but will be paid only one full DRG payment, inclusive of outliers.

2. Payments for hospitals excluded from prospective payment system.

a. Excluded from hospitals paid using PPS are psychiatric, rehabilitation, cancer and children's hospitals and psychiatric and rehabilitation distinct part units of hospitals.

b. Payment for inpatient psychiatric and rehabilitation services are made using a prospective per diem rate. The hospital or distinct part unit per diem rate is calculated based on the lesser of a maximum prospective per diem rate established for each type of service or 90% of a hospital or distinct part unit's calculated per day charge at June 30, 2002. The per diem rate may be inflated annually by the update factor determined in paragraph 1.f. The maximum prospective per diem rate effective August 1, 2002 is $450 per day for psychiatric services and $302 for rehabilitation services.

c. Effective January 1, 2002 inpatient services furnished by a hospital having an average inpatient length of stay greater than 25 days and designated a long-term care hospital by Medicare shall be paid on a prospective basis using a percentage of charges. The payment based on a percentage of charges is an all inclusive rate and is not subject to cost settlement. The percentage of charges effective January 1, 2002 shall be 50%. The effective percentage of charges shall be increased by the update factor provided under paragraph f of section 1 to PPS hospitals at the time that update factor is effective and decreased by a hospital's percentage increase in its charges on the effective date of the hospital increase in its charges.

Example: The department's update factors are 2.2%, effective July 1, 2002 and 3%, effective July 1, 2003. The hospital increases it charges by 5% on February 1, 2003. The percentage of charges and the effective dates are:

January 1, 2002	50%	
July 1, 2002	51.1%	(50% * 1.022)
February 1, 2003	48.67%	(51.1% / 1.05)
July 1, 2003	50.13%	(48.67% * 1.03)

d. Payments to cancer and children's hospitals are made based on a reasonable cost basis, using the Medicare methods and standards set forth in 42 CFR 413. An interim payment rate based on the hospital's cost to charge ratio from the latest available cost report will be made until such time as a cost settlement is made. The interim cost to charge ratio for a hospital which has not filed a cost report shall be 70%.

e. Indian Health Hospitals are paid inpatient per diem rates in accordance with the most recently published Federal Register notice.

3. Disproportionate Share Hospital (DSH) Adjustments.

a. Hospitals which provide services to a disproportionate share of Medicaid recipients shall receive a DSH payment subject to any limitations set forth in this section.

b. The following criteria must be met before a hospital is determined to be eligible for a DSH payment adjustment.

(1) A hospital must have:

(a) A Medicaid inpatient utilization rate of at least 1%

(3) If eligible, the state psychiatric hospital will receive a DSH payment adjustment calculated as an amount equal to $1.00 plus the state's disproportionate share allotment less the quarterly DSH payment adjustments made to all other eligible hospitals. The DSH payment adjustment to the state hospital will be made quarterly. The quarterly payment will be calculated by dividing the state's annual disproportionate share allotment by four and subtracting all disproportionate share payments made to other eligible hospitals in that quarter. Any adjustments to the state's disproportionate allotment will be corrected in the quarter the adjustment is made.

h. DSH payment adjustments will be limited as follows:

(1) Effective July 1, 1995 the DSH payment adjustment for any eligible hospital may not exceed the greater of the total of the unreimbursed costs of providing services to Medicaid recipients and of providing services to uninsured patients or the limitations set forth in section 1923(g) of the Act.

(2) If requested by the department, eligible hospitals must submit information on unreimbursed costs of providing hospital services to Medicaid recipients and of providing hospital services to uninsured patients before a DSH payment adjustment can be made.

(3) Total DSH payment adjustments paid to all eligible hospitals may not exceed the state's DSH allotment.

4. Out-of-State Inpatient Hospital Service Payments.

a. Out-of-state inpatient hospital service payments, except as identified below, shall be paid based on a percent of billed charges established by the Medicaid agency which shall not be less than 35%. The percent paid may be adjusted annually on July 1.

b. The department may negotiate a payment methodology for organ transplants performed by out-of-state hospitals.

5. Inpatient Psychiatric Services for Individuals Under 21.

a. Payments for inpatient psychiatric services for individuals under twenty-one provided in licensed residential treatment centers will be made using a prospective payment system developed by the state specifically for residential treatment centers as set forth in North Dakota Administrative Code, 75-02-09.

b. Payments for inpatient psychiatric services for individuals under twenty-one provided for in private psychiatric hospitals or psychiatric distinct part units will be made using the per diem rate established per paragraph 2.b.

c. Payments for inpatient psychiatric services for individuals under twenty-one provided for in the state hospital will be made based on reasonable costs. The state hospital will be paid on an interim basis using a cost to charge ratio until a cost settlement is made.